Standard Form 93
REV. OCTOBER 1974
GSA / FPMR 101-11.8

Approved
Office of Management and Budget No. 0704-0337
Approval expires 3-31-95

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.)

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
Mann, Michael Anthony	
3. HOME ADDRESS *(No., Street or RFD, City or Town, State, and ZIP Code)* x447 W. 90th Street x L.A., CA 90003	**4. POSITION** *(Title, Grade, Component)* CIVILIAN

5. PURPOSE OF EXAMINATION
(ENLISTMENT) COMMISSION
ARMY (NAVY) AIR FORCE MARINE CORPS
COAST GUARD RESERVE NATIONAL GUARD

6. DATE OF EXAMINATION
24 Aug. 95

7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*
LOS ANGELES MEPS, 5051 RODEO RD.
LOS ANGELES, CA 90016-4791

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists.)*

PRESENT HEALTH: Fair (cold)

CURRENT MEDICATIONS: Acne Creme

ALLERGIES (INCLUDING TO INSECT BITES / STINGS AND TO COMMON FOODS): None

9. HAVE YOU EVER *(Please check each item)*

YES	NO	*(Check each item)*
	✓	Lived with anyone who had tuberculosis
	✓	Coughed up blood
	✓	Bled excessively after injury or tooth extraction
	✓	Attempted suicide
	✓	Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	*(Check each item)*
✓		Wear glasses or contact lenses
✓	✗	Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
	✓		Scarlet fever, erysipelas		✓		Cramps in your legs (3)			✓	"Trick" or locked knee
	✓		Rheumatic fever		✓		Frequent indigestion		✓		Foot trouble
	✓		Swollen or painful joints		✓		Stomach, liver, or intestinal trouble		✓		Neuritis
	✓		Frequent or severe headache		✓		Gall bladder trouble or gallstones		✓		Paralysis (include infantile)
	✓		Dizziness or fainting spells		✓		Jaundice or hepatitis		✓		Epilepsy or fits
	✓		Eye trouble		✓		Adverse reaction to serum, drug or medicine		✓		Car, train, sea or air sickness
	✓		Ear, nose, or throat trouble						✓		Frequent trouble sleeping
	✓		Hearing loss		✓		Broken bones		✓		Depression or excessive worry
	✓		Chronic or frequent colds		✓		Tumor, growth, cyst, cancer		✓		Loss of memory or amnesia
	✓		Severe tooth or gum trouble		✓		Rupture / hernia		✓		Nervous trouble of any sort
	✓		Sinusitis		✓		Piles or rectal diseases		✓		Periods of unconsciousness
	✓		Hay Fever		✓		Frequent or painful urination				
	✓	✓	Head injury		✓		Bed wetting since age 12				
(1) ✓			Skin diseases		✓		Kidney stone or blood in urine				
	✓		Thyroid trouble or goiter		✓		Sugar or albumin in urine				
	✓		Tuberculosis		✓		VD - Syphilis, gonorrhea, etc.				
	✓		Asthma		✓		Recent gain or loss of weight				
	✓		Shortness of breath		✓		Arthritis, Rheumatism, or Bursitis				
	✓		Pain or pressure in chest (2)			✓	Bone, joint or other deformity				
	✓		Chronic cough		✓		Lameness				
	✓		Palpitation or pounding heart		✓		Loss of finger or toe	**12. FEMALES ONLY: HAVE YOU EVER**			
	✓		Heart trouble or murmur		✓		Painful or "trick" shoulder or elbow				Been treated for a female disorder
	✓		High or low blood pressure		✓		Recurrent back pain				Had a change in menstrual pattern
								DATE OF LMP			
								DATE OF LMP			

13. WHAT IS YOUR USUAL OCCUPATION?
High School Student

14. ARE YOU *(Check one)*
☐ Right handed ☑ Left Handed

EXCEPTION TO SF 93
APPROVED BY GSA/IRMS 4-92

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT.
		15. Have you been refused employment or been unable to hold a job or stay in school because of:
	✓	a. Sensitivity to chemicals, dust, sunlight, etc.
	✓	b. Inability to perform certain motions.
	✓	c. Inability to assume certain positions.
	✓	d. Other medical reasons *(If yes, give reasons.)*
✓		16. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*
	✓	17. Have you ever been denied life insurance? *(If yes, state reason and give details.)*
X	✓	18. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occurred.)* 5
24 mos	✓	19. Have you ever been a patient in any type of hospitals? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)* mom
✓		20. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
	✓	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses: *(If yes, give complete address of doctor, hospital, clinic, and details.)*
	✓	22. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*
	✓	23. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)*
	✓	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*

(16) Family Counseling, Doctor unknown, location unknown

Chicken Pox

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
Michael Anthony Mann	Michael Anthony Mann

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in item 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

(1) adm

(2)-(3) Osgood Schlatter's - pain in knees for 3 mo. only treatment - advil age 16 - no trouble since

16 - Family counseling - ? divorce

QUESTIONING REVEALS	YES	NO	DETAILS
MARIJUANA USE		✓	
OTHER DRUG ABUSE		✓	
ALCOHOL ABUSE		✓	
[redacted]			

never asthma

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
ELMER C. RIGBY, JR., M.D.	24 Aug	E C Rigby JR MD	

REVERSE OF STANDARD FORM 93

☆ U.S. GPO: 1992— 746-499